



Matthew Dunlap
Secretary of State

Department of the Secretary of State Bureau of Motor Vehicles

Catherine Curtis
Deputy Secretary of State

Robert E. O'Connell, Jr.
Director of Driver License Services

THIS IS THE ONLY MEDICAL REPORTING FORM THAT WILL BE ACCEPTABLE TO THE BUREAU OF MOTOR VEHICLES

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ TELEPHONE #: _____

CERTIFICATE OF EXAMINATION

FOR THE REPORTING PHYSICIAN:

1. This report is requested because the issue has been raised as to the possibility that this applicant may have a mental/physical condition which could affect his/her ability to drive a motor vehicle safely. Your report will be advisory and used to assist in determining eligibility for a driver's license. If you have any questions, please call the Medical Review Coordinator's office.
2. A physician acting in good faith is immune from any damages claimed as a result of the filing of a certificate of examination pursuant to 29-A MRSA Section 1258 (6)

FUNCTIONAL ABILITY PROFILE

This form cannot be completed without reference to the Functional Ability Profiles Booklet*
(*A copy of which may be obtained by calling 207-624-9000 Extension 52124)

DIAGNOSIS

(Please print or type)
If COPD, need O2 stats

PROFILE LEVEL

This section must be completed, check only one box per diagnosis

	1.	2.	3.				4.
			A	B	C	D	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of last examination (must be within last year): _____ How long has applicant been your patient? _____

For seizures or loss of consciousness, give date of most recent episode: _____

Current prescribed medication(s): _____

☐ No medication(s) prescribed Reliability in taking medication: Good ☐ Fair ☐ Poor ☐ Unknown ☐

Has this patient demonstrated any side effects from current medication(s) which would interfere with safe operation of a motor vehicle?

Yes ☐ No ☐ If yes, please explain:

(Important: please describe physical and/or cognitive deficits)

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on its right side, suggesting it's resting on a surface.

I hereby authorize the release of my medical history to the Secretary of State, Bureau of Motor Vehicles, for the purpose of determining my eligibility for a driver's license by:

Signature of Patient: _____ Date: _____
(Please forward this form directly to your physician for completion)

(Date) _____

Reply to: Medical Review Coordinator
Bureau of Motor Vehicles
29 State House Station
Augusta, Maine, 04333-0029
Telephone: 207-624-9000 Extension: 52124
Fax: 207-624-9319